DRAFT

MENTAL HEALTH SERVICES ACT (MHSA) IN SMALL COUNTIES IMPLEMENTATION CONSIDERATIONS FOR STAKEHOLDERS
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Purpose

The purpose of this discussion paper is to explore some of the issues small counties and their stakeholders face and strategies they might consider in their efforts to make the values and vision of the MHSA a reality in their communities. It is intended to serve as a springboard for further discussion among state policymakers, small county mental health departments, clients and family members who obtain mental health services in small counties and all other stakeholders.

Small counties face some unique challenges that are different from those experienced by their larger county counterparts. In any attempt to move beyond "business as usual" in the public mental health system, it may be necessary to develop some special strategies for these unique settings.

Issues and Strategies

Funding
Small counties need a guaranteed base amount of funding to be able to mount most programs. A straight funding formula based only on population often does not work. In a small county with minimum staffing and small client numbers but the same administrative requirements, programs can cost more to implement in a small county. Stakeholders might consider a graduated process for implementation based on amount of MHSA funding a county receives and population. As future years funding became available it would be expected that small counties would implement more of the MHSA either themselves or in cooperation with other counties.

At times it is hard for county staff to get resources and purchasing approved by the county even if the funding exist. Small county directors and the clients and family members they serve need to provide information to the county boards of supervisors and county administration about the benefits of the MHSA for residents served. However, even the best job of education at the local level is likely to fail if, at the outset, the State hasn't made enough funds available for

small counties to reform their system toward a recovery-based, client-centered model and away from the strictly clinically-based model of services.

Similar issues may arise in the case of MHSA Community Program Planning. A small county may have to hire both a planning consultant to assist them to do their MHSA plan and an in-house MHSA coordinator. While it is true that an outside consultant can help the small county develop their plans in the short-term there must be an in-house MHSA coordinator to make the implementation of those plans successful over the multi-year planning process. This would be someone who continues to work with stakeholders around the implementation issues unique in their particular county. Small counties typically have few administrative staff so, if funding is inadequate, direct service staff may have to be redirected to planning tasks and away from clients and family member care. This may create the exact situation the MHSA seeks to solve.

Stakeholder Involvement

Initially, it may be difficult to get clients, family members and other stakeholders to actively participate in an effort to move beyond "business as usual." Training by and for clients and family members will help them find their own voice in the small community. Training of all stakeholders and county staff is imperative but may not be enough. It may mean that county staff may need to go to where the clients and family members are instead of having clients and family members come to them. The vision of clients and family members must be included.

Clients and family members point out that, because of the cost of travel and the scarcity of alternative modes of travel, most training is local in nature. Education and conversation from outside the region or county brings in new ideas and new perspectives that are needed.

The MHSA allows counties to pay for necessary costs to involve clients, family members and specified others to facilitate their participation in the planning process. In a small county, authority under a new law can be less helpful than specific statewide MHSA regulations. If clear authority is not specified in regulation county counsels, county auditors, and/or Boards of Supervisors may hesitate to authorize new or unusual expenditures, fearing an audit exception at a later time. Even trivial audit exceptions can be big news in small counties.

Mental health services and supports may be limited in small counties. Stakeholders frequently are reluctant to complain about services, as they are afraid that to do so would mean they would lose those needed services. In small counties this is a particular concern as there are few, if any, private practitioners or other alternatives for necessary services and supports. Building trust will be a significant issue and will take time. In some small counties, the clients, family members, stakeholders and communities need to learn how to participate in a meaningful collaborative process if MHSA implementation is to be successful.

On the plus side small counties may have less difficulty with interagency collaboration. Community-based organizations, mental health directors and other county department heads may know each other on a first name basis.

Implementation
There needs to be some flexibility in how the requirements are implemented so that small counties and their stakeholders can initiate new programs based on individual county, client and family member needs, resources and readiness. The State will need to work with small counties and communities to provide them with technical assistance to increase their abilities to meet the intentions of the MHSA.

In order to meet the intent of MHSA, Section 5813.5(d)(2), small counties will have to develop some form of peer-operated services. This is consistent with the client recovery/wellness model and therefore is important to the changes necessary to move the mental health system in that direction. Small counties and stakeholders will need technical assistance to accomplish this. This means that not only must they be given the flexibility for how they do this they must be given sufficient time. This may be a project that will require several years to accomplish effectively. Small counties and their stakeholders should be encouraged to look at existing county models as well as review what is available online such as the National Mental Health Association's National Support and Technical Assistance Center (NCSTAC) at http://www.nestac.org.

Client and Family Member Employment
While employment for clients is a high priority in a client centered system, the problems of the stigma of mental illness and the resulting discrimination are significant obstacles. Small counties typically have high unemployment rates, making it difficult to find jobs for anyone. It is also true that hiring clients and family members is an excellent opportunity to fill county positions in particular with persons who have years of experience in navigating the public mental health system, living with symptoms of severe mental illness or serious emotional disturbance, and still lead lives filled with meaning and purpose. Clients and family members, as part of the mental health staff, can assist in developing the trust that needs to grow to help fight stigma issues in the community.

While many small counties do hire clients and family members it is frequently a difficult process. One possible solution is for a small county to have a contract with a nonprofit or a for-profit community-based organization to act as the employer for clients and /or family members. This strategy is frequently employed in larger counties. It allows for a more flexibility work schedule and supportive environment for clients and family members who may need it.

It is also important that small counties and their stakeholders work with local job development programs and community colleges to assist clients and family members to learn new job skills. Many already have the skills to go on to higher levels of education and/or to aspire to higher paying and satisfying work situations if provided with services and supports. Others may need assistance to get back into a career for which they are already qualified. The MHSA makes it clear that individualized plans need to be explored with individual clients and family members.

There is a particular problem for small counties when clients and family members work directly for the county. Since most small counties have few if any private practitioners of any type, and even fewer psychiatrists, the employed clients and family members must use the services of their employer. This adds complications to both the employee-employer relationship and the therapeutic relationship. This is not impossible to deal with and many counties have made this work.

Another problem encountered in attempting to hire clients and family members or assisting them to find jobs is the legitimate fear of losing an SSI entitlement. Often, this benefit has been obtained with great difficulty. If a job doesn't work out they fear they would be left without any means of financial support. This speaks to the importance of benefit counseling to assist clients and family members obtain a better understanding of allowable activities that will not jeopardize SSI.

Another strategy for employment might be a regional approach where there are few, if any, local community-based organizations available and a regional or a statewide organization could fill the role of employer contractor. This should be more fully explored as part of the MHSA planning process and could involve stakeholders and county mental health staff from several small counties.

Low Income Housing

Housing is a constant problem in many small counties. There is often strong opposition to the county taking on county housing responsibilities. Even where Section 8 housing is handled by the county there is always a long waiting list and those at poverty levels and/or without jobs often don't qualify. One allowable cost to be considered is to allow a county to contract with other entities to increase the availability of safe and affordable housing. Some small counties do have low-income housing, particularly apartment complexes, which clients may need help to access. These typically have long waiting lists of qualified low-income persons needing a home to live in.

“Not In My Back Yard” attitudes are as prevalent in small counties as they are in larger ones. While people will say they have no problem with low-income housing or other types of residential services in general, they don’t want it in their particular neighborhoods. There have been cases in which all necessary resources are available to develop housing but no location acceptable to the local community could be found.

Housing presents problems in areas where the cost of homes has accelerated or a small county is surrounded by larger richer counties and people move to the small county and commute. This has driven up the cost of affordable housing. At the same time salaries for those working in the small county area have not gone up significantly. With lower cost housing in short supply, the costs of renting has also increased.

This is an area in which small counties and their stakeholders could benefit from technical assistance. There are innovative programs out there in other counties that work. One such program consists of the county agency getting several clients together to find an appropriate home and share the costs of the rent. Another is contracting with local motels and being able to offer temporary housing for those clients not yet on SSI and do not have a source of income of their own yet.

Housing needs must be addressed not only for those totally homeless but also those in the homes of friends and family because they have no other place to go, as well as those in substandard and often unsafe housing. For the purposes of the MHSA our definition of homelessness must be expanded.

In the development of this paper, clients and family members explain in this sample quote how they manage to survive in such circumstances:

> "…In the small county if you are a client, other clients or family members in the community are now your family as well. You share resources, tales of woe and triumphs. For years you live in denial, and think it's a slump and as soon as you go back to work you'll be back on your feet. Only it's been years since you worked and are still supported by the client/family member community yet no one goes without a meal or a bed. It's also taxing on your friends and family by sharing limited resources and is emotionally draining because the household is always in this crisis mode."

Staffing

The shortage of qualified staff is an ongoing problem in most counties but is especially acute in small counties. There are few private practitioners and few if any local community-based organizations. The shortage of psychiatrists is especially difficult. There needs to infrastructure development to assist with increased costs in the use of telemedicine as a means to address this growing gap in resources.

Community organizations suffer the same problems as most small counties when it comes to hiring staff and keeping them after they're hired due to the

competition paying higher wages. Often small counties have been the staff training grounds for larger counties and agencies. In a county system that pays employees based on the financial resources available, different salary structures will continue to be a problem for those who cannot pay as well.

While small counties and communities may believe in cultural competency they can have a difficult time finding not only bi-lingual/bi-cultural staff but also competent interpreters. This makes delivering cultural competency services that much more difficult. This is an area in which the MHSA can be particularly helpful. The Education and Training component of the MHSA must assess and address these issues and provide technical assistance.

Stigma and Discrimination

Although there have been some strides made in helping the small community understand mental illness, fear based on ignorance, is still alive and prevalent. For too many people, the only exposure they have to mental health problems are in the movies, on TV, or when some public event occurs that hits the media. Stigma is one of, if not the most, significant problem which must be addressed if we are to truly make strides in helping clients live normal lives in ways the rest of us take for granted. Stigma creates barriers to employment, housing, and even health care. When the State develops a long-term statewide campaign we should see some real progress in the solution to these problems. Campaigns in the past were effective and made some impact but were like flashes-in-the-pan. It will take a long sustained public educational effort.

The impact of stigma and discrimination on the lives of clients and family members, whether served, un-served or underserved is very real. In the development of this paper, clients and family members explain in this sample quotes how they experience stigma in the small county environment:

> "…Once you do self-disclose your client or family member status, you're not invisible anymore. Everyone knows you, or of you and or your family, and once you have a break or a crisis it's the discussion of the day…Everyone has a scanner for fire and other information. People know when you get a ticket, CPS is called, if you go to the hospital or when mental health is paged out."

Regionalization

Regionalization is often suggested as a solution to issues of economies of scale for small counties and their stakeholders. In reality, regionalization most often is not an answer except in very limited circumstances. Geography is a real problem, not only due to vast distances and lack of transportation but also due to weather conditions.

Finding facilities to mount a regional program is often difficult. If a potential facility is found the “Not in My Backyard” syndrome can become an issue. Whereas many times if the community sees the program as serving only “their” residents they will be flexible but if it is seen as bringing in “outsiders” from elsewhere in the local region they will oppose the program.

Some regionalized efforts have been successful for example:

- For specific short-term programs such as regional inpatient services or long-term treatment programs and residential programs where the client is expected to return to their home county. These are resources that for economies of scale a specific county cannot mount a cost-effective program on their own.
- A regional provider that is able to supply staff and resources direct for a specific service in individual small counties. Examples of this would be EPSDT providers who provide staff for 24/7 coverage for children to keep them out of higher levels of care. A provider is stationed in one county but hires staff in each county and/or sends staff to the contract county to do the service.
- A very small county contracts with an adjoining county to do a service or a program that they are too small to mount on their own.
- Two or more counties combine in a joint powers agreement and do a common complete mental health program. This works when the population centers are very close to each other and can share outpatient staff with a common clinic or a common inpatient unit. An example is the Sutter-Yuba Counties Mental Health Program. There have been several of these efforts in the past but this is the only one that has had any real staying power.
- The Small Counties Managed Care Risk Pool is successful because these were done through joint powers agreements and adopted by-laws.

All of these should be explored in the stakeholder planning process as small counties implement the MHSA.

Recommendation

The MHSA vision can become a reality for clients, family members and other stakeholders in small counties. The problem areas noted above are very real but can be overcome given stakeholder collaboration and partnership, mutual respect and trust and flexibility in program timeframes and implementation strategies. DMH should give special time and attention to these needs and initiate discussion and problem solving that will benefit all who live in small counties.